

## GPEI Response to Recommendations in the 8<sup>th</sup> IMB Report—February 14, 2014

<i>Recommendation</i>	<i>Status</i>
<p>1. (Pakistan) We recommend that achieving access in FATA be top priority for Pakistan’s polio program and all who support it, using all diplomatic means available.</p>	<p>A comprehensive multi-pronged approach is being undertaken to seek access in the two key areas of FATA: Bara Tehsil in Khyber Agency; and North and South Waziristan. The current overall strategic approach is to negotiate a locally developed and supported plan for vaccination in North Waziristan instead of reversing the Ban imposed by militants.</p> <p><b>1) Advocacy with the Federal Government:</b> Senior officials of GPEI partner agencies and WHO/UNICEF regional and country teams have initiated multiple high-level interventions that focused on gaining access to children in FATA. GPEI partners engaged with the President, the Prime Minister, the Minister of State for Health, the Prime Minister’s Focal Person for Polio; and the Prime Ministers’ Adviser on National Security and Foreign Affairs. Advocacy efforts are also underway to engage the new Minister of Defence, and the Minister of Interior. Members of the Pakistan National Assembly have also been engaged. The Prime Minister is expected to again Chair the 2<sup>nd</sup> National Polio Task Force meeting in end February; immediately following the meeting of the Executive Board of WHO in January, WHO-DG has written to the Prime Minister requesting an urgent meeting; recently the DG met with the PM’s Focal Person on Polio. GPEI has also advocated with key donor partners (G8, China, GCC, the EC) to highlight the issues of access to children, and the attacks on health workers with the leaders of Pakistan during bi-lateral discussions, as well as multilateral fora such as a WHO and UNICEF Executive Board meeting, and the UK and European parliament debates. The Polio Partners’ Group meetings have also been a channel for donor governments to engage with the Pakistan delegation. Members of the US Congress, the US State Department, and members of the UK and EU Parliament have been briefed by Rotary and other partners. Key Ambassadors of Pakistan in New York, Washington DC, Geneva, London and Beijing have also been engaged. The UN, at the highest levels, and the OIC have also been engaged in sharing relevant messages with the leaders of Pakistan, as well as influential donor governments. The UAE has also been engaged to advocate with the Federal Government as well as the military leadership of Pakistan. The global community’s strong expression of concern about the killing of health workers and the risk of international spread has provided additional impetus to the Government of Pakistan to address the issue of access to children in FATA.</p> <p><b>2) FATA and Provincial Governments:</b> Senior GPEI partners and WHO and UNICEF country and Regional Office leadership have made multiple interventions with the Governor of FATA who is responsible for Khyber, South and North Waziristan; the key officials in the FATA Administration: Chief Secretary, FATA; the Additional Chief</p>

Secretary; Secretary Social Welfare.

Further to GPEI advocacy, the Governor of FATA included polio eradication in the agenda of the monthly APEX Committee meeting between the Governor and the Military Commanders in the region. Limited vaccination activities reaching 7,000-8,000 children have been conducted in South Waziristan, primarily in the Mehsud tribe areas.

Senior GPEI partners and WHO/UNICEF Country teams have engaged with the Chief Ministers of the provincial governments of Khyber Pakhtunkhwa (KP), and Punjab given their influence with the Federal government on broader political discussions on FATA and talks with non-state actors. The political party of Mr Imran Khan, PTI, which governs KP province, has also been actively engaged to support vaccination efforts in greater Peshawar as it is also the home to thousands of IDPs from FATA, and maintains close relations with FATA local authorities. With UNICEF support, Mr. Khan is spearheading a communications campaign for polio and broader health, which promotes local accountability and puts a Pashtun, popular face to polio eradication in KP. This localized, Pashtun approach was a key outcome and recommendation of the UNICEF/BMGF BrainTrust meeting held in October. GPEI partners are also working with the UAE Crown Prince's Office to create more visibility for regional, Islamic partners who can have greater influence and trust in FATA and KP. The Crown Prince's Office is developing a communications strategy in close collaboration with the GPEI that can help provide support for PTI efforts at local level. Rotary has also supported strengthened communication efforts by providing more than 500 mobile phones to critical staff in the area.

**3) Religious Leadership:** There has been significant mapping by UNICEF country team of various religious leaders, religious institutions and their influence networks. In collaboration with WHO and the Islamic University of Islamabad, plans are being developed for the Pakistan National Islamic Advisory group and Provincial Islamic Advisory group to actively assist the programme following a very frank and fruitful discussions in Islamabad. Rotary has also engaged senior Islamic leaders to support the initiative and address community concerns. Key Islamic leaders with significant influence among non-state actors in Waziristan have also been engaged, and have been engaged multiple times, including by WHO Regional Director for EMRO. A number of supportive statements, FATWAs have been produced and delivered, and critical meetings have been organized by the religious leaders with interlocutors of the non-state actors. The current Peace Talks committee of the non-state actors includes religious leaders engaged by the polio programme.

Renowned Islamic leaders from Saudi Arabia, Egypt, Qatar, and the International Islamic Fiqh Academy in Jeddah (the highest body of Islamic jurisprudence) have also been engaged by WHO, with the close collaboration of all GPEI partners, to issues strong statements in support of polio vaccinations, safety of OPV, and condemning the attacks on health workers. The first meeting of the global Islamic Advisory Group is scheduled in Jeddah during the

	<p>last week of February 2014.</p> <p><b>4) Military Leadership:</b> GPEI has engaged with the leadership of the Military and the Frontier Corps in Peshawar who are responsible for FATA. A Civil-Military Coordination committee was established to ensure necessary inputs to the Military, particularly with regards to access in Bara Tehsil in Khyber. When periods of curfew have been lifted in Bara tehsil, the military has provided security for the conduct of vaccination activities. The scope of these activities are not fully apparent, due to ongoing conflict. Military leadership have also been engaged to share information on the critical status in North Waziristan and to explore opportunities where vaccination activities could be conducted when districts open up, or when IDPs could be targeted in neighbouring districts.</p> <p><b>5) Third Party mediation:</b> WHO is exploring, through third party mediation, organizations with access to non-state actors from FATA, various modalities to provide vaccines for communities in North Waziristan.</p>
<p>2. (Nigeria) We recommend that the Nigerian Expert Review Committee ensures that detailed area-specific plans are in place to overcome the challenges in each of the Local Government Areas (LGAs) that need priority focus.</p>	<p>Since the last IMB report, the Nigeria program has implemented a range of tools to better address LGA-specific problems. Those innovations that have been successful have been incorporated into the 2014 Nigeria Polio Eradication Emergency Plan. Among the efforts to better address problems in LGAs:</p> <ul style="list-style-type: none"> <li>• Deployment of more Management Support Teams to high risk LGAs for adequate supervision one week in advance of each campaign based a new formula: if the ward reports &gt;10% missed children in 3 – 4 polio campaigns (as per independent monitoring) then 3 MSTs will be deployed; and if the ward had 1-2 rounds &gt;10% missed children then 2 MSTs will be deployed.</li> <li>• Revision of micro-plans with incorporation of GIS maps information and enumeration, to be completed by March 2014 (note: a physical walk-through of 19 LGAs in Kano State increased the number of settlements in the microplans while reducing the target population by 1.5 million children)</li> <li>• Re-deployment of government and partners staff based on competence; this will be completed by February 2014</li> <li>• New team structure: teams are being reduced from 4 member to 3 to allow for a greater number of teams. This new team structure will be fully implemented by March 2014</li> <li>• Continued (every 6-month) re-evaluation of the LGA priority list and LGA-specific needs</li> <li>• Rapid scale up of ‘health camps’ conducted during each IPD (e.g., Kano State plans to conduct health camps in all wards in all 44 LGAs from March onwards through the next five campaigns)</li> <li>• Retraining of vaccination teams, by February 2013</li> <li>• Full provision of social mobilization human resources and planned demand creation commodities by February 2014</li> <li>• Reaching underserved populations continues to be an important priority in 2014. Underserved populations</li> </ul>

refer to those populations that have been demonstrated to have a higher likelihood of not receiving regular services i.e. nomadic and other migratory populations, populations living in hard-to-reach areas, scattered or border settlements. It is likely these populations serve as a hidden reservoir of WPV and contribute to movement of virus across state and international borders. Surveillance in these communities is challenging and efforts are ongoing to improve detection and reporting from these areas. The program has a plan, based on experience over the last year and a half in working with these populations, for enumerating the children in these settlements, incorporating the settlements into AFP surveillance and adding these communities to existing micro-plans. The focus will be Borno, Yobe, Kano and Bauchi.

Borno has a unique set of challenges that are being addressed with a different set of strategies. In Borno, there have been continued improvements in access to children affected by insecurity. The program estimates 54% of the target population could not be reached in June 2013 (910K children), while 14% of the target population could not be reached in December 2013 (240K children). In areas where the program is operational, there are problems with quality, as measured by LQAs (50% of LQAs lots accepted at  $\geq 80\%$  in June, compared with 23% in December 2013). The Maiduguri airport was bombed in December, making it more difficult for external monitors and partners to support the state program. Road travel to Borno is also extremely hazardous. Despite these challenges, the program has set the following targets:

- Conduct 4 “Catch-up” OPV campaigns in wards that did not participate in planned IPDs rounds by May 2014
- Conduct 3 “Hit & Run” mop-ups to all wards with WPV and accessibility challenges that did not achieve high quality IPDs during “catch-up” contacts by May 2013
- Permanent Health Teams established in all wards with inaccessibility challenges and persistent non-compliance with monthly reporting of data
- “Fire-walling” established in all LGAs on the borders of Borno and Yobe by March 2014 with monthly reporting of coverage data
- Health Camps established and expanded to reflect the number of poor performing wards and non-compliant sites by May 2014
- Child Health Weeks established in specified LGAs in Borno, Yobe, Kano and Bauchi by June 2014

<p>3. (Horn of Africa outbreak) We recommend that a joint WHO-UNICEF central command unit is established for the Horn of Africa, led by a single senior commander.</p>	<ul style="list-style-type: none"> <li>• <i>Horn of Africa outbreak coordination:</i> On January 20th, the WHO EMRO and AFRO Regional Directors announced the appointment of a single polio coordinator, based in Nairobi, to coordinate outbreak control activities across the partnership in Somalia, Ethiopia, Kenya, Djibouti, Eritrea, Sudan, South Sudan, Tanzania, Uganda and Yemen. As part of this mission, the coordinator was asked to set up a single outbreak response operations room in Nairobi and to convene twice-weekly coordination meetings with all of the relevant partners. The coordinator’s terms of reference also include ensuring continued country-level advocacy and coordinating donor relations and resource mobilization efforts, including regular donor updates.</li> <li>• <i>Middle-East outbreak coordination:</i> This outbreak also requires a coordinated response in several countries in at least two WHO regions. In coordination with WHO/HQ, the EMRO regional director rapidly appointed a high-level coordinator and within a month appointed a coordinator to remain in place until the outbreak is controlled. This coordinator is placed in WHO’s Emergency Management Support Team in Amman and coordinates closely with UNICEF’s Middle East/North Africa office, also in Amman. A WHO-UNICEF joint strategic plan was rapidly developed in November with on-the-ground technical support from other partners, including CDC and BMGF, this unit coordinates with governments and non-governmental partners in the region, including in Syria, Turkey, Iraq, Jordan, Lebanon and Egypt.</li> </ul>
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<p>4. (Horn of Africa outbreak) We recommend that the Polio Oversight Board is immediately appraised of what partner staff are required in, and in support of, the Horn of Africa and oversees measures to get them in place by the end of November.</p>	<p>A “Polio Oversight Board Scorecard” has been developed to share with the POB on regular basis, starting with their call on January 10, 2014. One element of that scorecard is, “GPEI partner agencies adequately staffed – Percent of approved posts vacant.” Data are displayed by agency (WHO, UNICEF, CDC) for both HQ positions and positions in each of the three endemic countries.</p> <p>In the Horn of Africa, the status of positions in the partnership are as follows:</p> <p>UNICEF: As of 16 Dec 2013, UNICEF has 41 posts in Somalia, South Sudan, Uganda, Ethiopia, Kenya, and Regional office in Kenya. Out of 41, 27 posts are international and 14 posts are national. Out of 41 posts 7 posts are vacant and out of which 6 are international and 1 is national.</p> <p>CDC: As of December 2013, CDC had temporarily detailed staff to work in the WHO/Somalia, UNICEF/Somalia and WHO/Kenya offices. In addition, two staff members were assisting the WHO program in Addis Ababa. CDC had also selected a candidate for a 2- to 6-year assignment in Nairobi to work on immunization issues, including polio eradication, in the region.</p> <p>WHO: As of the end 2013, the following is the status of the temporary 'surge support' positions in the Horn of Africa: of the planned 18 international positions, 16 were filled; of the planned 170 national positions 153 were filled. Of the total 188 positions, 169 were filled.</p>
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<p>5. (Horn of Africa outbreak) We recommend that environmental surveillance be urgently established in Nairobi, Kenya.</p>	<p>Following HoA TAG and the 6-month outbreak assessment mission, the recommendation to establish Environmental Surveillance in Nairobi has been implemented and pilot testing commenced in October 2013. , Implementation will be in two phases. Phase 1 is for three months of pilot testing with the initial sample processing in Kenya and virologic testing in CDC, Atlanta. Phase 2 involves building dedicated cell-culture and viral isolation capacities/facilities in the KEMRI Polio laboratory in Nairobi. The detection of WPV1 in one of the pilot samples collected in October has accelerated the scaling-up of environmental surveillance in Nairobi and other cities. An expansion plan is being discussed and should be finalized by end February 2014.</p> <p>Environmental surveillance has been expanded in recent months to include the following locations:</p> <ul style="list-style-type: none"> <li>- Nigeria: 8 new sites were added in three new states between May and Oct 2013, i.e Kaduna (2 sites), Federal Capital Territory (2 sites) and Borno (3 sites). In total 19 sites are now functional in 6 states.</li> <li>- Afghanistan: 3 new sites (first ones in the country) were opened in Kandahar from Sept 2013.</li> <li>- Environmental surveillance was expanded in India (Punjab province which is bordering Pakistan: 4 sites) and China (10 sites in 10 provinces now, including Xinjiang province).</li> </ul> <p>Future plans</p> <ul style="list-style-type: none"> <li>- In the African Region feasibility will be assessed and implementation initiated in Chad, Niger, Mali, DR Congo, and Angola in 2014.</li> <li>- In the Eastern Mediterranean Region sites will be expanded in other parts of Afghanistan and Pakistan and inclusion of other countries is under discussion.</li> </ul> <p>The 2003 Environmental Surveillance guidelines are being updated and aligned with the Endgame strategic plan and will be finalized by end of March 2014.</p>
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<p>6. (Israel) We recommend that Israel immediately schedules a second national OPV campaign, to be completed as quickly as possible.</p>	<p>Israel reached &gt; 80% coverage of children &lt; 10 yrs old nationwide during the first bOPV round which began on August 4, 2013 in the southern district and was expanded to cover the whole country from August 18 onwards. This first SIA ended in late September. Coverage was higher than average in the southern and northern district, and lower in large cities (Tel Aviv, Jerusalem).</p> <p>On 6 October, the national immunization advisory committee recommended to re-introduce 2 doses of bOPV to augment the 5-dose IPV schedule. When it became clear that transmission of WPV1 had not stopped in the south, a limited second vaccination campaign began in mid-October. However, this activity selectively targeted only communities with environmental surveillance continuing to detect WPV1. Coverage in the targeted communities, all of these were Bedouin Arab communities in the southern district, plateaued at 40% due to non-compliance of the target population and the activity was stopped.</p> <p>While environmental surveillance since mid-2013 showed that transmission was progressively limited to the southern district, several sewage sampling sites in the south remain WPV-positive up to the present time. A sample collected in January 2014 in Gaza Strip is positive for WPV1.</p> <p>The WHO DG met with the Deputy Prime Minister of Israel, Mr. A. Libermann, in early January, and recommended that Israel conduct another OPV campaign urgently. The Chairperson of the European Regional Polio Certification Commission visited Israel during the week of 2 February to discuss the situation and its implication for the certification status of Israel and the European Region</p> <p>Main outcomes and feedback to the national authorities were as follows:</p> <ul style="list-style-type: none"> <li>• The RCC will need to see robust evidence, i.e. environmental surveillance showing negative results for at least 6 months, to accept that the circulation of WPV1 has indeed been interrupted, and expects the Israeli National Certification Committee (NCC) to submit such evidence in time before the June 2014 meeting of the RCC.</li> <li>• The intensity of surveillance must be maintained. Sewage sampling must continue weekly from present positive sites and should only be relaxed to monthly after at least four negative consecutive weekly samples are obtained.</li> <li>• The new immunization schedule which incorporates two doses of bOPV in addition to 4 doses of IPV must be actively promoted and implemented.</li> </ul>
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<p>7. (Israel) We recommend that the WHO Director General briefs Member States whose populations are currently protected against polio by IPV only on the implications of circulating poliovirus in Israel.</p>	<p>WHO HQ has alerted member states repeatedly through Disease Outbreak News IHR event site about the situation in Israel and the risk of international spread of WPV from Israel. A detailed progress report on polio, including an update on Israel and on the current polio outbreak in Syria, was shared with the Executive Board (EB) members and made available publically during the recent meeting of the EB.</p> <p>Also, both the WHO European Regional Office and the European CDC have shared with member states and published alerts and updates on the situation in Israel, informed the public about the threat of wild poliovirus spread from Israel and from Syria, and provided advice on measures countries can take to manage the risk of importation.</p>
<p>8. (Outbreaks waiting to happen) We recommend that a global action plan be drawn up, identifying a definitive Red List of the world's most polio-vulnerable countries and actions to protect each of them.</p>	<p>The partners conducted a detailed risk analysis to identify and agree on the 'Red List' of countries at high risk for a polio outbreak. The analysis on evaluation of available data from currently polio-free countries, by 1st sub-national level, on: 1) history of importation events as a 'proxy' measure for probability of importation; 2) susceptibility to polio transmission indicated by OPV dose status of n-p AFP cases 6 to 59 mo; and 3) known risks with direct population links to currently infected countries or areas, such as southern Turkey, Lebanon and Iraq. A risk mitigation matrix has also been developed for the countries on the list. The matrix has been reviewed with regional offices and will be used in collaboration with regions to track implementation of mitigation plans. The current draft of the Red List includes: African Region: Central African Republic, Chad, Cote d Ivoire, DR Congo, Mali, Niger, S. Sudan; Eastern Mediterranean Region: Iraq, Lebanon and Yemen; European Region: Turkey.</p>

<p>9. (Outbreaks waiting to happen) We restate our earlier recommendation that the International Health Regulations be used to ensure that all people travelling from a polio-endemic country be required to have vaccination prior to travel, and add that this should be extended to any persistently affected country.</p>	<p>The Director General of WHO convened a Senior Policy Group at WHO to review the situation and options to reduce the risk of international spread of polio, particularly through vaccination of travellers. DG advised the program to convene a panel of technical experts on polio to review the current WHO recommendations on vaccination of travellers and advise on practical implementation guidelines for countries. In response to concerns expressed by Member States about the risk of international spread of polio and their request to the DG during the recent meeting of the Executive Board of WHO to convene an Emergency Committee under the IHR, the DG has decided to convene an Emergency Committee under the IHR after the expert technical consultation and before the World Health Assembly in May 2014.</p> <p>The SAGE Polio Working Group met in early February to review the existing recommendations on vaccination of travellers, consider the new evidence related to duration and boosting of mucosal immunity and immunogenicity of OPV and IPV in the context of international travel, and recommend to SAGE changes in the current recommendations on vaccination of travellers.</p>
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<p>10. (Insecurity) We recommend that the Polio Oversight Board ensures that all of the planned security posts within the partner agencies are filled by the end of November, even if this requires extraordinary measures.</p>	<p>UNICEF has dedicated Polio security advisors who provide an analytical capability at HQ, Afghanistan and Pakistan with additional positions being introduced in areas where polio exists. This capability has been further developed with the creation of a ‘talent pool’ of security analysis experts who can deploy at short notice to address existing issues of insecurity and inaccessibility or respond to future outbreaks. These security analysis experts work with programme staff to analyse the underlying cause of inaccessibility and local dynamics, then plan and implement mitigation measures to ensure acceptance of the programme among the population. The security analyst was first introduced in Afghanistan in 2011 with great success and helped reduce the number of children reported as being in hard to reach areas particularly in the south of the country.</p> <p><b>As of 31 January, UNICEF has the following posts:</b></p> <p><b>NYHQ</b> –international post recruited and in place who also gives technical support to regional offices and Countries</p> <p><b>Afghanistan</b> - International post recruited and in place.</p> <p><b>Pakistan</b> – International post in Islamabad recruited and in place. 4 x National staff members in key locations. 2 x posts filled, 1 x post to join in immediate future and 1x post under recruitment.</p> <p><b>Nigeria</b> – International post in Abuja under recruitment – shortlist provided to Representative. 3 x National staff members in key locations.</p> <p><b>Recommendations for further posts: Polio Regional Security Advisors in WCARO, MENA and ESARO. A National staff member is recommended to cover East Region, Afghanistan.</b></p> <p><b>As of 31 January, WHO has the following posts</b></p> <p><b>GenevaHQ</b> - --international post recruited and in place who also gives technical support to regional offices and Countries</p> <p><b>Afghanistan</b> – International post in place and 3 x National staff (Kandahar, Kabul, Jalalabad)</p> <p><b>Pakistan</b> - International post in place (temporary), 2 x National staff (Islamabad and Karachi) and 2 x National staff under recruitment (Quetta and Peshawar)</p> <p><b>Nigeria</b> – 3 x International post in place (Abuja, Kano, Bauchi) and 3 x National staff (Kano, Borno, Bauchi)</p> <p><b>Somalia</b> – 1 x International staff under recruitment, currently covered by a senior security officer</p> <p><b>Syria</b> – 1 x International staff under recruitment</p> <p><b>Recommendations for further posts: 2 x National staff in Somalia and 1 x National Staff (short term) in CAR.</b></p>
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<p>11. (Insecurity) We recommend that the partners consult and seek advice from the highest levels of the UN Security system and other experts.</p>	<p>UNICEF and WHO have drafted a common security approach to the GPEI known as the ‘Joint Security Approach’ (JSA). This policy aims to set common definitions of inaccessibility and insecurity, standards of security analysis and suggested security support structure in different types of countries (endemic, outbreak, high risk or ‘red list’). The approach also aims at providing a mechanism to pre-empt possible future outbreaks as well as a means to improve oversight and accountability.</p> <p>The JSA takes a ‘supportive approach’ of security analysis to support the regional and country offices rather than giving directives. After the discussion and endorsement by the GPEI, the JSA document will be released in a phased approach – details to be confirmed.</p> <p>The meeting with USG UNDSS will be initiated once joint security approach is endorsed by GPEI. The meeting will be attended by Bruce Aylward (WHO) and Mickey Chopra (UNICEF) and the proposed agenda will be:</p> <ul style="list-style-type: none"> <li>• An overview of the Polio Programme (highlighting the issue that the areas where the polio virus exists are in locations where children are hard to reach due to insecurity and inaccessibility)</li> <li>• The introduction of the JSA</li> <li>• Specific issues arising from endemic, outbreak and red-list countries</li> <li>• Determine ways that UNDSS can support the GPEI</li> </ul>
<p>12. (Insecurity) We recommend that all means be used to ensure that the polio program in every country is known to be politically neutral.</p>	<p>The programme very strongly concurs with the need to remain politically neutral.</p> <p>The Polio Programme in each country – a partnership between national governments, WHO, UNICEF, Rotary – maintains its focus on its core objective to reach and vaccinate all children in the country consistently and thereby stop wild poliovirus transmission. While all public health initiatives, by their very nature, operate in an intensely political environment, WHO and UNICEF country teams conduct their activities based on the “Core humanitarian principles” of humanity, neutrality, impartiality and independence.</p> <p>The polio programme does have to closely monitor its actions given the numerous political differences between various levels of the host government, and the myriad social, religious and cultural factors involved in conducting mass vaccination campaigns in complex countries. The local community perceptions of the UN, various UN agencies, and also the various donor governments supporting the programme, all have an impact on the “interpretation of neutrality” of the polio programme.</p> <p>The polio programme’s focus on impartiality in the delivery of its services – to all children – is a stronger measure of the programme’s adherence to core humanitarian principles.</p>

<p>13. (GPEI Management) We recommend that the Polio Oversight Board commissions a comprehensive review of the program's oversight and strategic and operational management, making a decision now about how to optimally time this.</p>	<p>This recommendation was discussed in detail by the Polio Oversight Board (POB) in its meeting on 10 January in the context of current progress and challenges to stopping WPV transmission and the changes the Board is making to ensure major donors to GPEI are engaged and appropriately consulted on major decisions in the program. In follow up to the discussion, the POB is currently reviewing options related to the scope, areas of focus, optimal timing, and potential mechanisms for such a review.</p>
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<p>14. (IPV) We recommend that the program agrees and makes a clear statement of policy on the use of IPV in stopping polio transmission, addressing the questions raised by the IMB in its May and October 2013 reports.</p>	<p>In 2013, the GPEI’s Innovations Work Group put together a “white paper” on the use of IPV together with OPV to accelerate eradication. This has been shared within the partnership and with countries considering IPV use to accelerate eradication.</p> <p>Since then, the following has occurred:</p> <ul style="list-style-type: none"> <li>• <i>Use of IPV during the December 2013 SIA in the Dadaab Refugee Camp, Kenya:</i> During the December SIA in Kenya, IPV was used in approximately 120,000 children in the Dadaab Refugee Camp and surrounding communities. The vaccine was well accepted by the community and the logistics were feasible, although there were isolated mistakes with injection. Preliminary coverage estimates based on parental recall were 94-96%, except in nomadic communities (38%), where OPV coverage was also low. The estimated per-child costs were \$2.00 for the vaccine and \$0.56 for administration (this compares with \$0.25 for an OPV-only campaign). This experience is being written-up for publication and sharing with other programs.</li> <li>• <i>Nigeria:</i> the program is planning to integrate IPV use into its permanent health teams in Borno. In addition, the program is looking to begin using IPV as part of routine immunization, probably starting with two states.</li> <li>• <i>Afghanistan:</i> During the August NIDs, the program is planning to use 540,000 doses of IPV in low-performing districts in the southern and eastern regions</li> <li>• <i>Pakistan:</i> The program is currently resolving some regulatory issues, but hopes to use 400,000 doses in Peshawar in May, 300,000 doses in transit points in various locations, 100,000 doses in Karachi, and 1,400,000 doses in FATA and KP during a measles campaign in May. In addition, the program plans to maintain a stock of 500,000 doses to use in newly accessible areas.</li> </ul> <p>As of the week of February 13<sup>th</sup>, the UNICEF Supply Division is working on procuring vaccine for IPV introduction into routine immunization programs. However this IPV supply tender does not account for IPV use in SIAs. Currently, GPEI is still in the process of finalizing plans for using IPV in SIAs to provide Supply Division with a better estimate of demand and timeline in order for Supply Division to provide a more accurate assessment of the supply situation.</p>
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<p><b>Communication and social mobilization</b></p> <p>Social mobilization and communications is mission-critical. The response to our report, which highlighted the relatively weak past performance in this area, has been encouraging. However, the IMB is still not satisfied that the program has embraced the concept that communication is everybody's business. With UNICEF's social mobilisation network now comprising 19,000 individuals, achieving operational excellence is key. General principles and good practice are important, but the lessons from the front line are that solutions often need to be very context-specific to small localities. A skilled local mobiliser who uses her creativity to persuade a reluctant mother that the anti-vaccine propaganda</p>	<p>Since the last IMB report, community acceptance and demand for OPV has continued to rise. With over 11,500 community mobilizers working in the highest risk areas of Afghanistan, Pakistan and Nigeria, refusals have been reduced by nearly 60% in 2013, to only 0.7% globally in the 3 endemics. In all countries, social mobilizers are helping to identify the most trusted influencers in each locality, and are enlisting these religious, community and traditional leaders to be champions for polio eradication. In Pakistan, a 1000 Mosque Strategy for Peshawar aims to enlist 1,000 religious leaders to deliver local messages for polio. Mothers are speaking more publically on behalf of other mothers, led by a new media campaign featuring a polio-affected mother and her grown children speaking about the impacts of polio on their lives. Pashtun influencers are becoming more visible in the campaign as local champions as well, following a strategic shift identified during the BrainTrust meeting to promote a localized brand for the campaign in KP and FATA. In Nigeria, over 300 religious focal points and a number of polio survivors have been identified to raise risk perception of polio and provide trusted advice to caregivers about vaccination, and in Afghanistan, the programme is exploring how to increase the proportion of female mobilizers who can enter households and engage with mothers to reduce the proportion of children missed because they are a newborn, or are sick or sleeping when the team visits.</p> <p>Innovations are being explored to poll frontline workers more frequently with SMS or Interactive-Voice-Recognition technology. Rapid polling using the UNICEF-designed software U-Report can allow frontline workers to confirm whether or not they've been paid, can poll workers on their knowledge of polio and RI messages, or help them to report on insecurity when they feel threatened. Nigeria and Afghanistan will be the first to roll this out in 2014.</p> <p>Harvard Polling Data has been analyzed for 14 accessible districts of Pakistan and 3 districts of South-Central Somalia (with more data to come from N/S Waziristan, Puntland and Somaliland in the coming month). Both data sets show extremely high rates of community acceptance for OPV. Refusal to vaccinate in both countries is negligible, at less than 0.5% in all areas. However, the data also shows clear areas of operational and social vulnerability.</p> <p>In South-Central Somalia and all areas of Pakistan except FATA, nearly 100% of caregivers are aware of polio. FATA is the only outlier, with 11% of caregivers who have never heard of polio or a disease that causes paralysis. Additional analysis is being undertaken to understand who these 11% may be, and why the programme seems to be missing them entirely. In both countries, there are significant misperceptions about whether or not polio is curable, with over 30% of parents in both countries believing that there is a cure for polio, or unsure about it. In FATA, nearly half of caregivers said they had heard in a destructive rumor, which is nearly three times the level reported by caregivers in the rest of the country. Parents here are also more likely to believe the rumour, which</p>
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<p>that she has been subjected to is not in the interests of her child is worth her weight in gold.</p>	<p>may explain why parents are confirming fewer vaccinations and less intent to vaccinate than in other parts of Pakistan.</p> <p>Mogadishu and FATA identified clear coverage gaps in accessible areas, with only 81% of parents in Mogadishu saying their child received polio drops, compared to over 93% in Baidoa and Afgoye. In FATA, 66% of caregivers in accessible areas say their child received polio drops, compared to 99% in the rest of Pakistan.</p> <p>Vaccinator profile and quality is an area that needs very careful review in FATA. Only 25% of caregivers say they have a great deal of trust in the vaccinator that visited their home in the last round, compared to 61% in the rest of the country. Here, only 29% of parents said the vaccinator that visited their home was from their local community, compared to 69% in the rest of the country's high risk areas. Additional indicators show that vaccinators here were not as respectful to parents, and were perceived to be less knowledgeable about polio.</p> <p>Health and education were the top two priorities for parents in Mogadishu; in FATA, power shortages and clean water were the most commonly cited priorities.</p> <p><b>Communication is Everyone's Business</b></p> <p>Rotary has been particularly active in social mobilization and communication activities in Pakistan. For example, in January 2014, Rotary and Coca-Cola Beverages Pakistan inaugurated a Reverse Osmosis Water Filtration Plant in Malir, Karachi to build community confidence and trust. At the local level in Nowshera, KPK, the Pakistan Rotary Polio Resource Centre played a crucial role in the integration of health workers and Traditional Birth Attendants (TBAs) with social mobilizers and polio partners. These TBAs along with Lady Health Workers administered OPV to each newborn in all the four high risk Union Councils of Nowshera. The TBAs are well rooted in their communities and are considered credible among families living in the same areas. They are valuable in conveying information on health and hygiene, refusals and the importance of vaccines to mothers in high risk areas. Data is compiled on these newborns by the Resource Centre and provided to local EPI at Union Council level and COMNet staff of UNICEF to socially mobilize the community and particularly parents for OPV.</p> <p>Rotary International and UNICEF Pakistan launched the Speaking Book titled '<b>A Story of Health</b>' to mark World Polio Day. The book, in Pashtun and Urdu is an educational tool for community workers to engage with women, children and fathers to tell them of better sanitation and hygiene and ensure people know the importance of vaccines in the prevention of diseases. The Speaking Books is pioneered by a Rotarian in South Carolina, USA. The book has been sponsored by Rotary International, designed in South Africa, illustrations and voice over and storyline were completed in Pakistan and finally printed in China. A lot of thought and creative effort has gone into</p>
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producing these speaking books to reach out to Pashtun speaking communities in KPK, FATA and Karachi.

WHO provides the epidemiologic situation and risk analysis to guide social mobilization strategies and identify communication objectives in specific risk areas and populations. Analysis on programmatic and operational challenges is shared with UNICEF and other partners to help design outreach and community engagement. WHO helps in monitoring and analyzing data on the impact of communication strategies on reduction in missed children. WHO guides, facilitates and in some settings leads on strategic management of media and broad public communications to promote program effectiveness and public and partner support. WHO/EMRO in collaboration with UNICEF has constituted the global Islamic Advisory Group and a national Islamic Advisory Group in Pakistan to engage key religious and community leaders.